

## Solidarity is for other people: identifying derelictions of solidarity in responses to COVID-19

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# **“SOLIDARITY IS FOR OTHER PEOPLE: IDENTIFYING DERELICTIONS OF SOLIDARITY IN RESPONSES TO COVID-19”**

**Peter West-Oram**

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## **Abstract**

The role and importance of solidarity for effective health provision is the subject of lengthy and heated debate which has been thrown into even sharper relief by the Covid-19 pandemic. In various ways, and by various authorities we have all been asked, even instructed, to engage in solidarity with one another in order to collectively respond to the current crisis. Under normal circumstances, individuals can engage in solidarity with their compatriots in the context of public health provision in a number of ways, including paying taxes which fund welfare state initiatives, and avoiding others when ill. While there has been significant engagement in solidarity worldwide, there have also been high profile examples of refusals and failures to engage in solidarity, both by individual agents, and governments.

In this paper I examine the consequence of these failures with reference to the actions of the current British government, which has failed to deliver an effective response to the crisis. This failure has effectively devolved responsibility for responding to the crisis to people who are simultaneously more vulnerable to infection, and less able to do anything about it. I argue that such responses represent not only mismanagement of a public health crisis, but also a rejection of important democratic and egalitarian norms and values.

## **Introduction**

While the role and importance of solidarity has been the focus of long-running and extensive debate surrounding public health ethics and practice,<sup>(1)</sup> the Covid-19 pandemic has cast this debate into even starker relief.<sup>(2)</sup> In doing so, it has emphasised the particular importance of solidarity for the delivery of effective public health programmes by highlighting the potentially disastrous consequences of its absence. In this paper I examine these consequence with reference to the response of the current British government to Covid-19 which failed to deliver an effective public health response to the crisis. I argue that this response represents not only mismanagement of a public health crisis, but also a rejection of important democratic norms and values.

## **Defining Solidarity**

Solidarity has a wide range of definitions in academic discourse, with its precise features being the subject of heated debate.<sup>(3,4)</sup> Historically, solidarity has been seen as emerging most readily, and most often between persons sharing relatively stable, deeply ingrained qualities, such as shared membership of a state or religious group,<sup>(5)</sup> or commitment to shared political ideals and objectives.<sup>(6,7)</sup> More recently, it has been suggested that more transient, or less deeply ingrained features of persons may serve as the basis for acts of solidarity, and at least short term solidarity relationships.<sup>(4)</sup> On a larger scale, it has also been suggested that recognition of shared

vulnerability in the face of global threats to health, such as climate change and antimicrobial resistance, may serve as a catalyst for solidarity between nations and peoples.(8) As I explain below, this perspective is particularly relevant to the current pandemic context.(2)

In this paper I rely mainly on the definition of solidarity offered by Prainsack and Buyx, who define solidarity as “enacted commitments to accept costs to assist others with whom a person or persons recognise similarity in a relevant respect”.(4) Therefore, solidarity describes what it is that we do when we assist, benefit, or support other people because we recognise some form of relevant similarity or connection with/to them. Thus solidarity is *active*, in that it is something we *do*, not merely a feeling or attitude. It is also egalitarian, with motivation for action being grounded in recognition of what is *shared* between parties, not in what distinguishes them.(3) Finally, acting in solidarity also involves incurring of costs of some kind, though these may be extremely minimal, or be counterbalanced by the benefits of a given solidarity action.

Prainsack and Buyx argue that there are three main “tiers” of solidaristic action; interpersonal, group, and institutional solidarity.(4) The first of these tiers describes what happens between individual persons. For example, Prainsack and Buyx suggest that giving up one’s seat on a crowded bus for a pregnant fellow passenger is an act of solidarity when based on recognition of shared experience of discomfort while standing during pregnancy.(4) The second tier “comprises manifestations of a *shared* commitment to carry costs to assist others with whom people consider themselves bound together through at least one similarity in a relevant respect”. These group solidarities occur when many individuals share a similar specific context, and engage in actions to benefit others with whom the context is shared. Such solidarity is informal, though it may also be heavily normalised within a given community, such that it forms an expectation of behaviour.

Tier three solidarity comprises formalised, or legally mandated expectations of behaviour. Here, solidarity is fully institutionalised, “in the form of

legally enforceable norms”,<sup>(4)</sup> such as progressive tax systems and welfare state arrangements. For example, the British National Health Service exemplifies institutionalised solidarity, because it is funded through taxation and provides health care to citizens and legal residents of the United Kingdom, regardless of their ability to pay. According to Prainsack and Buyx, these three tiers of solidarity are closely connected, with tier three solidarity typically emerging from solidarity at tiers one and two. Correlatively, Sangiovanni discusses the participation in collaborative institutions as solidaristic practice when he argues that solidarity is grounded in “our joint action as authors of *political and social institutions*”.<sup>(7)</sup> Thus, for Sangiovanni solidarity is something which emerges from shared participation in the construction and enactment of civic society. Solidarity can therefore be interpreted in a range of ways – as the act of carrying costs for relevantly similar others, “*standing up for*”, “*standing up with*”, and “*standing up as*” those persons with whom solidarity is identified,<sup>(3)</sup> or the act of working together for a shared goal.<sup>(7)</sup> Regardless of the precise definition adopted, at least basic solidarity, as active engagements in interpersonal and/or institutional egalitarian relationality, by all or most members of a group is fundamentally necessary for the existence and functioning of any community – as I explain below, it is particularly important in democracies.

## **Solidarity and Public Health**

In normal circumstances, private individuals can engage in interpersonal and group solidarity in the context of public health provision, by avoiding social interaction when sick and helping others to do the same, by purchasing groceries for an ill neighbour for example. Individuals can engage in tier three solidarity by participating in institutions which promote and protect public and individual health. For example, participation in fair taxation schemes can help fund health and welfare programmes, such as the British National Health Service (NHS), ensuring the accessibility of these services to

all members of a given community, thereby contributing to public health and individual wellbeing.

Correlatively, while elected and appointed governmental officials, such as cabinet ministers, can also engage in solidarity in the same way as their constituents, they also have additional responsibilities in virtue of their public role and status as elected representatives of their communities. These responsibilities include things like enacting legislation which establishes and maintains institutions and programmes which promote and protect health. Such actions not only protect the health of their constituents, they also enable those constituents to more effectively engage in solidarity with their peers, by providing the systems necessary to do so most effectively, and guidance as to the reasons for so doing. It is therefore particularly important that elected officials engage in solidarity with their constituents in this manner because individual citizens lack the capacity to establish and govern public health institutions, and more importantly, have deferred authority to do these things to those in government through the democratic process.

The delivery and maintenance of effective public health programmes relies on most members of a community engaging in solidarity in a range of ways. To illustrate, vaccination programmes cannot deliver herd immunity without mass participation from community members, but individuals cannot contribute to herd immunity if vaccines are prohibitively expensive, or only available at an inaccessible venue. They are also unlikely to contribute if they have been misled into believing that vaccines are dangerous or unnecessary. Here, engagement in solidarity is required from both private individuals, who must participate in the programme, and elected officials, who must ensure it is accessible to all members of a community, and provide an epistemic context in which the importance and safety of the programme is widely understood, in order for it to be effective.

## **Solidarity and Covid-19**

In his opening remarks to a press briefing on the 18<sup>th</sup> of March 2020, Tedros Adhanom Ghebreyesus, Director-General of the World Health Organisation (WHO) stated that “[the] spirit of solidarity must be at the centre of our efforts to defeat COVID-19”.<sup>(2)</sup> Similar statements have also been made by a number of other agencies, each of which have emphasised solidarity’s role as an essential part of an effective public health response.<sup>(9)</sup> Correlatively, many governments have instituted lockdowns, and are enforcing social distancing measures (to greater or lesser extent) in order to limit the spread of infection. We have all thereby been asked, even instructed, to avoid public gatherings, minimise our contact with others, and help to protect our neighbours. In so doing, we engage in solidarity with our compatriots.

For private individuals, engaging in solidarity with their peers in response to Covid-19 is thus very similar to such engagement for public health under normal circumstances – participation in public health programmes, social distancing, community cooperation, and contributing through taxation to the cost of public health efforts and medical research. Elected officials can do these things as individuals, but can also respond in their role as public officials in at least two additional ways; first, by collaborating with other governments to share information, and coordinate regional and global public health responses.<sup>(10)</sup> Second, by ensuring that national health services exist and are adequately funded, staffed and equipped to be able to respond to the pandemic, and by providing clear information and support to citizens so that they may engage in solidarity with one another.

There has been great variation in the extent to which different regions have achieved engagement in solidarity across these vectors; New Zealand and South Korea both implemented thorough testing and tracing programmes which allowed them to counteract the spread of infection (and in South Korea, also reduced influenza infections), while New Zealand also imposed strict lockdown protocols, going as far as closing its borders.<sup>(11, 12)</sup> Equally importantly, officials in both locations acted quickly, and communicated clearly with their communities, ensuring that residents knew how to minimise

the risk of transmission, and why doing so was important. Individual members of these communities were thus able to engage in interpersonal solidarity, by following lockdown rules, maintaining social distancing, and participating in track and trace programmes, because their governments had proactively established the material and epistemological conditions where such engagement was enabled, empowered and encouraged. By doing so, the New Zealand and South Korean governments thus engaged in solidarity with their constituents.

In contrast, the current British government's response to Covid-19 lacked the transparency, clarity, and urgency which characterised the actions of these more successful nations. First, while the UK and New Zealand each initiated lockdowns in the same week in late March, New Zealand at that stage had only 102 cases of Covid-19, with no deaths, compared to the UK's total of 5687 cases, and 281 deaths.(12, 13) Correlatively, while South Korea did not enforce a strict lockdown, it had enacted social distancing policies even earlier, at the end of February.(11) The risk of ongoing transmission was therefore significantly higher in the UK than in either nation at this time.

Second, communication from the current British government was often unclear, and the Prime Minister and other officials frequently downplayed the severity of the pandemic – at one point the Prime Minister (who was later hospitalised with Covid-19) stated that he would not refrain from shaking hands, and that he had recently shaken hands with everyone in a Covid-19 ward.(14) In this way, the risks of Covid-19 were initially minimised in official communications, creating uncertainty about how to act, and which guidance to follow. Exacerbating this issue, where advice *was* given, it was initially often discretionary, and little material support was made available to enable people to follow it. For example, on the 16<sup>th</sup> March 2020, people were advised to work from home *if possible* and avoid social venues, such as pubs and theatres.(15) However, this was not mandatory, and social venues were not required to close until the 20<sup>th</sup> of March, so some employees were required to work onsite, despite known risks.(16)



Correlatively, no support was initially made available to those who could not work remotely, meaning that choices had to be made between employment and “fighting the virus”. Financial support was later made available, in the form of the government’s job retention scheme, which allowed employers to furlough non-essential workers, the wages of whom would be subsidised by government.<sup>(17)</sup> However, this only covered 80% of employee wages, meaning that many of those furloughed would have to live on a reduced income. Likewise, while support has been offered to homeowners in the form of mortgage holidays, at the time of writing, renters have not received similar assistance.<sup>(18)</sup>

Third, the government also initially moved to adopt a strategy that deviated from the recommendations of the World Health Organisation (WHO), which focused on minimising infection rates through conventional public health measures, such as active testing, social distancing, and increased emphasis on personal hygiene (hand washing etc).<sup>(19)</sup> In contrast, the government initially endorsed a “herd immunity” strategy, which appeared to focus on allowing approximately 60% of the British population to become infected with the virus, which would have led to an even higher level of excess mortality.<sup>(20)</sup> Despite the eventual rejection of this strategy in favour of closer adherence to WHO guidelines, at the time of writing the UK has the world’s second highest Covid-19 mortality rate.<sup>(21)</sup> Further, the consequences of these policy choices were compounded because of the historical policy context in which they occur. In the last decade the National Health Service has seen a significant reduction in funding as a result of austerity policies.<sup>(22)</sup> Consequently, many NHS trusts have found it extremely difficult to respond safely and effectively to the crisis, because of lack of resources (in terms of people, money, and equipment) – the absence of sufficient personal protective equipment for those treating Covid-19 patients being particularly notable.<sup>(23)</sup>

The current British government’s response to Covid-19 therefore deviated significantly from those of nations with more successful responses, and from

WHO guidance. In doing so, it established an epistemological and financial context where it was difficult for individuals to afford to follow public health guidelines, or to even know exactly what those guidelines required. As I argued above, the successful delivery and maintenance of public health programmes requires engagement in solidarity from both private individuals, and government officials. Engagement in solidarity by the latter entails legislating for the delivery and management of effective public health programmes, and providing clear guidance for their constituents to follow.

Unlike their counterparts in New Zealand and South Korea, the current British government has failed to achieve either of these objectives, though it should be noted, that there have also been high profile instances of individual agents in the UK failing to engage in solidarity with their communities.<sup>(24)</sup> However, these solidarity failures must be considered in context; arguably some failures of individuals to engage in solidarity may at least in part be attributed to governmental failures to deliver an effective public health response to Covid-19, or communicate its importance and requirements. It has been noted for example, that panic-buying and stockpiling can be sensible strategies in times of potential social chaos and market disruption – especially when told by the government that a total social lockdown may imminently limit access to necessities.<sup>(25)</sup> In each of these cases, the individuals concerned *do* have duties of solidarity (as well as professional duties, in the case of health care workers) to their compatriots and communities, and failure to fulfil them may cause harm. However, the costs and challenges of fulfilling those duties have been amplified (and in the case of the professional duties of health care workers dangerously so) by the government’s failure to fulfil its own responsibilities of solidarity.

## **Conclusion**

Effective public health programmes cannot rely solely on private individuals always engaging in interpersonal solidarity in an optimal fashion. Private citizens all operate under epistemological constraints – we may not know of the needs of others with whom we would engage in solidarity if we had more

complete information, or we may be honestly mistaken about the best way to engage in solidarity with people we do know about. Alternatively, we may know of the needs of others, but face material constraints which make providing significant assistance to them impossible. Governments must therefore engage in solidarity with their constituents by providing the epistemological, institutional, material, and financial resources, which compensate for these constraints and thus make interpersonal solidarity possible. By failing to do so, the current British government has failed to adequately protect the residents of the United Kingdom in a time of crisis. It has thus failed to engage in solidarity with its constituents, and effectively devolved responsibility for action to agents with far less power to deliver an effective response to Covid-19. Further and importantly, those thus tasked with responding to the pandemic are disempowered in part because of the failures of the government.

Had the government's failures in response to Covid-19 occurred despite the early adoption of recommended strategies proven to work elsewhere, they would not count as failures of *solidarity*, but of policy – as unfortunate consequences of mistakes made under challenging circumstances, despite a good faith effort to achieve the best possible outcome. The government's actions became failures of solidarity when it ignored compelling and accessible information about how best to respond to the crisis, and did not take actions that they could and should have taken. Further, by failing to provide either definitive rules, or sufficient material and financial support, the government devolved responsibility for responding to the crisis to their constituents and expected them to each individually act in the correct manner to prevent the spread of infection – an unrealistic expectation. As discussed above, private individuals operate under significantly stricter financial, social, and epistemological constraints than their elected representatives, constraints which in this instance were exacerbated by the actions of those in power. Even under ideal conditions (that is, in the absence of material and epistemological constraints), reliance on mass individual choices delivering an appropriate response to Covid-19 would not be an effective strategy. To

rely on such a strategy where such constraints are present is not only mistaken, but arguably avoidably so. It is also a dereliction of the government's responsibilities to its constituents.

Importantly therefore, the government's actions represent more than mere failure to adequately protect its constituents. By devolving responsibility for action to those without sufficient power to act, the government's actions should be recognised both as a failure of solidarity, and as a dereliction it. Indeed, where engagement in solidarity by the government has occurred, it has frequently been delayed, insufficient, or reluctantly provided, contributing to the significant excess mortality and morbidity experienced by the UK.(21)

A government which fails to engage in solidarity with its constituents, makes an implicit statement about the nature of the relationship between itself and the rest of society. In doing so, and in abdicating their responsibilities to their constituents while simultaneously expecting them to collectively deliver an effective response to Covid-19, they redefine that relationship, from being one of elected representatives and constituents, to one of rulers and ruled.

There are two ways to interpret the phrase "solidarity is for other people"; first, it can be read as a statement of closeness and relationality – an expression of the understanding that solidarity is something we engage in to assist or benefit other people with whom we identify. Second, it can be understood as an assertion that the speaker holds themselves apart from other people – a claim that solidarity is something that *other* people should or may do, but that is not something with which the speaker is concerned. Sadly, recent events suggest that we must give serious consideration to the idea that it is this second interpretation which more accurately reflects the attitudes of the British government at this time.

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